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 beneverepharmacy.com

TODAY'S DATE: _____
 NEW PATIENT CURRENT PATIENT

ASTHMA REFERRAL FORM

PATIENT INFORMATION

Patient Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____
 DOB _____ SSN _____
 Drug Allergies _____ Male Female
 Patient Weight _____ Height _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____
 NPI# _____ Tax ID _____
 Practice Name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____
 Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____
 Policy# _____ Group _____ Policy# _____ Group _____
 Insurance Phone _____ Insurance Phone _____
 Prescription Drug Coverage Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if available) _____

CLINICAL INFORMATION

Primary Diagnosis: _____ ICD-10: _____
 Current Therapies: Antihistamines Beta agonist (circle one): Long-acting Short-acting Corticosteroids (circle one): Inhaled Nasal Oral Decongestants
 Immunotherapy _____ months Leukotriene modifiers Other: _____
 Previous Treatment: Naive Restart Continued therapy; date: _____
 Lab results: History of positive skin OR RAST test to a perennial aeroallergen Pretreatment serum IgE level _____ IU/mL; date _____ Other _____

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 200mg PFS <input type="checkbox"/> 300mg PFS	<input type="checkbox"/> Induction: Inject 2 syringes under the skin on day 1, begin maintenance on day 15. <input type="checkbox"/> Maintenance: Inject 1 syringe under the skin every other week.	14-day supply 28-day supply	0
<input type="checkbox"/> Fasenra®	<input type="checkbox"/> 30mg PFS	<input type="checkbox"/> Induction: Inject 30mg under the skin every 4 weeks for 3 doses. <input type="checkbox"/> Maintenance: Inject 30mg under the skin every 8 weeks	84-day supply 56-day supply	0
<input type="checkbox"/> Nucala®	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Inject 100mg under the skin every 4 weeks. <input type="checkbox"/> Inject 300mg under the skin every 4 weeks.	28-day supply	
<input type="checkbox"/> Xolair® Limited Distribution	<input type="checkbox"/> 150 mg vial <input type="checkbox"/> Xolair Supplies <input type="checkbox"/> EpiPen <input type="checkbox"/> EpiPen Jr. <input type="checkbox"/> No supplies	<input type="checkbox"/> Inject _____ under the skin every 4 weeks <input type="checkbox"/> Inject _____ under the skin every 2 weeks ***Dose based on IgE level and weight. Please provide pertinent laboratory data.	28-day supply	

Patient has received injection training Physician's office to provide injection training Benevere Rx to coordinate injection training

Deliver to: Patient's home MD's Office 1st dose to MD's Office, remaining refills to patient's home

Statement of Medical Necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient's treatment accordingly and all information is accurate to the best of my knowledge. I authorize Benevere as my designated agent and on behalf of my patient to (1) provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above named patient.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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